

Idaho Substance Abuse Treatment and Recovery Support Services

Direct any and all questions, or concerns to: _____

Consent for Release of Information

I, _____ (Print Program Participant's Name), am requesting treatment from Idaho's publicly funded substance abuse treatment and recovery support system. I voluntarily authorize Business Psychology Associates (BPA) and substance abuse treatment and recovery support providers in BPA's system of care network for the Department of Health and Welfare (Department) to disclose my name, all necessary treatment information and my social security number to each other and to the Department. This information will be disclosed for the following purposes:

1. To assist with referring me to appropriate type of care and guiding my treatment and recovery support;
2. To be entered into the Department's common client database so that I will have one client number for any services I receive from the Department;
3. To process payment of costs for my treatment and recovery support services; and,
4. For monitoring compliance in the program.

I consent that my records may be reviewed by independent peer reviewers, contract monitors or researchers appointed by the Department.

I understand that no information will be provided to sources other than those specified above without my written consent, or are otherwise mandated by law.

This release may be revoked at any time either orally or in writing, except to the extent that action has already been taken in reliance on the release. I acknowledge that some information may include material that is protected by state and federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. Unless revoked as stated above, this consent expires automatically on: _____.

Client Name (printed)		Witness Name (printed)	
Client Signature	Date	Witness Signature	Date
Parent/Guardian (printed)		Parent/Guardian Signature	Date

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT STATEMENT.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.